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ABSTRACT

This report summarizes the meetings of the World Health Organization (WHO) Working Group on Family Planning and Sex Education of Young People, which was attended by advisors representing education, sociology, psychology, pediatrics, demography, obstetrics and gynocology, family planning, and psychological medicine. The advisors were from eight countries, from UNESCO, from the International Planned Parenthood Federation, and WHO staff and consultants. The scope and purpose of the working group and its definitions of adolescence and family planning are given in the introduction. The present situation in Europe and obstacles to sex education and family planning services for young people are reviewed, based on a study by the WHO Regional Office for Europe, which emphasized strategies used in various countries for providing sex education and family planning. Develoment of sex education programs is discussed in the areas of curricula, staff training, and program implementation. Development of family planning services is discussed, focusing on the place of such services in the health service structure, roles and training of staff, and service acceptability. The report concludes with guidelines for educational programs, including content and staff training; guidelines for provision of family planning services, including organization, setting, and staff; and general recommendations. A list of participants, and summaries of the report in French, German, and Russian are included. (JAC)

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Family planning and sex education of young people

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The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health problems of the countries it serves. The European Region has 32 active Member States,[*] and is unique in that a large proportion of them are industrialized countries with highly advanced medical services. The European programme therefore differs from those of other regions in concentrating on the problems associated with industrial society. In its strategy for attaining the goal of "health for all by the year 2000" the Regional Office is arranging its activities in three main areas: promotion of life-styles conducive to health; reduction of preventable conditions; and provision of care that is adequate, accessible and acceptable to all.

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Family planning and sex education of young people

Report on a WHO meeting

Copenhagen
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INTRODUCTION

A Working Group on Family Planning and Sex Education of Young People was convened by the WHO Regional Office for Europe and held in Copenhagen from 1 to 5 November 1982. The meeting was attended by a total of 11 temporary advisers from eight countries, from UNESCO and from the International Planned Parenthood Federation (IPPF), together with staff and consultants from the Regional Office and WHO headquarters. The disciplines represented included education, sociology, psychology, paediatrics, demography, obstetrics and gynaecology, family planning and psychosexual medicine. The meeting was opened on behalf of the WHO Regional Director for Europe by Dr A.H.W. Wahba, Director, Development of Comprehensive Health Services, WHO Regional Office for Europe.

Scope and purpose

To explain human sexuality, biological, physiological, psychological and social factors have to be considered. Security, self-respect and appreciation of the self, including the body, are important prerequisites for rewarding sexual experiences. An adequate understanding of this and of the various roles played by men and women, primarily in their own but also in other societies, is necessary for the fulfilment of the individual in his/her sexual capacity as well as in his/her capacity as a partner and as a father or mother. Learning how to relate to others as potential partners requires the support of the older generation. The individual needs to be informed about basic biological, physiological, psychological and social facts. In order to acquire security and self-respect, which are important for rewarding relationships, the young need not only basic facts but positive reinforcement.

Since it is in the interest of every society that its members are secure, have self-respect and take a responsible attitude to their sexual life, it is in the interest of every society to prepare its members for future sexual activity.

In view of the above, the WHO Regional Office for Europe has conducted a study on family planning and sex education of young people,[a] the emphasis being on identifying the various strategies used in different countries for providing such services. The report on the study served as a background document for the Working Group, which consisted of people from international organizations working in the field, resource persons working with programmes found to be of particular interest during the study, and people in responsible positions from countries intending to start or recently having started programmes of family planning or sex education for young people.

The purposes of the Working Group were:

- to review the present situation in the Region, and to discuss obstacles to and develop strategies for the further development of family planning and sex education for young people;
- to discuss the special merits and shortcomings of various approaches;
- to identify human and organizational resources for follow-up and to issue recommendations on the provision of family planning and sex education for young people.

The meeting reflected growing WHO interest in vulnerable groups, of which young people are one.

A system of plenary sessions and small group discussions was used. In the plenary sessions invited papers were presented as an introduction to the particular topic under consideration. The meeting was divided into two groups — one made up of those primarily involved in education, the other of those primarily involved in providing family planning services. Issues discussed were reported back in the plenary sessions and a record was kept of major points raised so that they could be incorporated in the final recommendations.

DEFINITIONS

General definition of adolescence

The report on a meeting on service-oriented research in adolescent fertility,[b] convened by the Regional Office in 1978, contains a comprehensive

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[a] **Lewin, B.** *Sex and family planning: how we teach the young.* Copenhagen, WHO Regional Office for Europe, 1984 (Public Health in Europe, No. 23).

[b] *Service-oriented research in adolescent fertility:* report on a WHO Meeting. Copenhagen, WHO Regional Office for Europe, 1979 (EURO Reports and Studies, No. 1).

and detailed definition of adolescence and its concomitants, from which the following definition of adolescence was drawn.

> In general terms, adolescence may be defined as a period of transition from childhood to adulthood. This transformation involves three main types of maturation: physical, psychological and social.

A detailed account of the stages of maturation is to be found in the aforementioned report.

Adolescence is a state during which there are great variations in physical and mental development. Sociocultural and legal differences between countries also make it difficult to lay down a universal definition of the age range of adolescence.

Sometimes the term "young people" is used instead of "adolescents". The introduction to the questionnaire sent to all Member States of the WHO European Region in connection with the above-mentioned study on family planning and sex education of young people states:

> Young people should here be understood as children and adolescents below the age when people in your country usually marry or start to cohabit under marriage-like conditions.

General definition of family planning

Family planning was defined by a WHO Expert Committee in 1970[a] as follows:

> Family planning refers to practices that help individuals or couples to attain certain objectives: to avoid unwanted births; to bring about wanted births; to regulate the intervals between pregnancies; to control the time at which births occur in relation to the ages of the parents; and to determine the number of children in the family. Services that make these practices possible include education and counselling on family planning; the provision of contraceptives; the management of infertility; education about sex and parenthood; and organizationally related activities such as genetic and marriage counselling, screening for malignancy, and adoption services.

REVIEW OF THE PRESENT SITUATION IN THE REGION

A multiplicity of changing conditions has created a new situation worldwide. Better nutrition and social conditions have resulted in earlier development and growth, with puberty, the onset of sexual activity and the possibility of pregnancy occurring at an earlier age.

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[a] WHO Technical Report Series, No. 476, 1971, p. 8.

An increasing movement from rural areas to towns, migration to other countries and the dwindling impact of religion have combined to reduce the acceptance of previous precepts and practices. Education has been extended and has delayed the adoption of adult roles and responsibilities, so that adolescence has been prolonged, making it even more important for society to provide information and services that facilitate the transition from youth to responsible citizenship, and to minimize early unwanted pregnancy — with its risks to the health and life of mother and child — and the penalties of disruption of education and training that can lead to economic disadvantage and continuing financial dependence on society.

Sex education for young people

Sex education for young people in the European Region ranges from areas where it is a compulsory and accepted part of the school curriculum to areas where it is non-existent. In no country is it prohibited by law.

Even in countries where it has been compulsory since 1971 and integrated into the school curriculum, the specific aim of preventing sexual and personal problems due to ignorance of sexual matters has not been completely met, as judged by data presented by one participant and based on a questionnaire to schoolchildren. It is recognized that knowledge alone will not prevent emotional and personal problems in this essential area of life, but the findings revealed a lack of preparation even for immediate events such as puberty. Twice as many boys (25%) as girls (12%) reported that they had had *no* information prior to the event and were unprepared for the biosocial changes of menarche and spermarche. The median age when information on sex was introduced was 12–13 years for boys as well as girls, and only a minority had had any sex education before the age of 10 years.

The primary source of sex education for boys was the teacher (53%), with mothers (5.5%) the next most frequent source, while for girls mothers (41%) and teachers (32%) were quoted. Fathers played a very small part. As a group girls were better informed at an earlier age and had knowledge of a wider variety of topics. Boys were found to be much more dependent on teaching at school.

The fact that fathers were hardly ever mentioned may reflect the fact that in many societies they spend less time with their children and are less involved in their intimate care. It may, however, also be due to the fact that women relate sex to reproduction and babies, which provides an easier introduction to the topic, whereas many men relate it more to pleasure or desire, which may be harder to share.

It was recognized that not all teachers are naturally adept at sex education, although their skills can be improved with training, which should be part of the basic teacher-training syllabus. Similarly, doctors

and nurses may have the factual knowledge that would appear to make them suitable sex educators, but they may be unskilled in communication and would also benefit from further training.

The contribution that could be made by young people themselves to the format of sex education was considered, and it was appreciated that a better understanding of what was appropriate for inclusion at different stages could be gained by listening to them. For example, younger children defined sex as what they felt about their bodies, its development and its differences rather than about coitus and pregnancy. Emotional concerns of older children can involve getting to know the opposite sex socially and the practice of petting before considering a full sexual relationship. Groups of young people have been known to plan their own programmes of sex education to include what was of interest to them at different stages, and with suitable speakers to address them on what they wanted to hear about. As well as reliable factual information on physical development, conception, contraception, sexually transmitted diseases, pregnancy and birth, they wanted to understand about masturbation, abortion, homosexuality and the range of the sexual spectrum, and particularly to be able to discuss intensity of feelings and how to relate responsibly to the opposite sex.

The question was asked "Is it really so bad that youngsters should experience the romantic young love of which they are physically capable, if they are also emotionally stable and mature enough for it, if homes and schools can provide them with adequate and psychologically desirable sex education?". It was recognized that many young people had sexual relationships. Surveys have recorded considerable variation in the age of first coitus; for example, in one country 34% of males and 17% of females had experienced coitus by the age of 18, whereas in another the figures were 59% of males and 37% of females. In a representative sample from a city in a third country about two thirds of the girls, but only one third of the boys, had experienced intercourse by the age of 16. Given this incidence, a programme of sex education and provision of contraceptive services was considered essential to enable the young to reach adulthood without the burden of early pregnancy.

Obstacles to sex education for young people

In countries where sex education is not part of the accepted curriculum and is being introduced and expanded, great sensitivity has to be exercised to allow for public opinion and cultural and religious mores. Sectors of the public may consider that, because of their own moral values, information given in a sex education programme could have a corrupting influence on the young and they will try to prevent its introduction. The term "sex education" may be an obstacle in itself, as it is often seen in isolation as "education in sexual intercourse" rather than as a preparation for

adulthood. A variety of terms has been used to try and place it in a wider context and make it acceptable to local culture:

- health and sex education
- education for family life
- humanization of the relationship between the sexes
- preparation for parenthood
- education for responsible parenthood.

Obstacles to the provision of sex education were identified under the following categories:

- obstacles within society
- obstacles within the service system
- obstacles within the target group.

Obstacles within society

Legal

- Dissemination of information, such as being unable to discuss abortion in some countries
- Specific restrictions, such as the mass media restricting the advertising of contraceptives

Cultural

- Unacceptability by the local authority
- Parental resistance
- Lack of public awareness of the problem
- Resistance by religious groups
- Traditional values (e.g. sex roles), attitude towards marriage, etc.
- Socioeconomic aspects
- Educational level
- Demographic aspects, such as pronatalist or antinatalist government policy
- Ethnic minority groups with different values
- Availability of educational programmes

Obstacles within the system

- Resistance to change at management level
- Lack of sex education in curricula for teacher training

- Conflicting messages/information from different sources
- Conflict between values transmitted in formal and informal systems
- Obstacles within the person providing education, sometimes leading to avoidance of dealing with sexuality by medicalizing the issues
- Vertical teaching systems
- Lack of consultation between teachers and school health personnel
- Traditionally organized systems, classroom teaching, didactic teaching, etc.
- Lack of specific integration of information in the curricula
- Lack of sex education material appropriate to the needs of adolescents both within and outside the school
- Lack of knowledge about the concerns of adolescents
- Lack of adolescents' influence on what they want to learn, and lack of involvement in the teaching.

Obstacles within the target group

- Inhibition when working in groups
- Lack of trust in teachers (due to their attitude, sex, age, appearance, lack of knowledge, etc.)
- Different stages of sexual maturation among members of the target group
- Lack of trust of the school system (confidentiality, etc.)
- Pressure from peer groups (values, behaviour)
- Culture conflict as with children of migrants and young migrants
- Physical or mental handicap

With the identification of some of the obstacles, it will be easier to develop strategies to overcome them at the different levels.

Family planning services for young people

Whereas most governments try to remove the stigma attached to teenage pregnancy and are aware of its incidence, there is not always agreement on the provision of family planning services for young people and these vary throughout the Region. In some countries family planning for young people is available within the national health service, from family doctors as well as family planning clinics and special centres for the young. In others the outlets are few and the provision of contraception to those under 18 may be prohibited by law.

Even when contraception for young people is legal, services may be limited because of the fear that being seen to provide facilities will be considered an encouragement to early and premarital intercourse and promiscuity.

Most young people do not consider the term "family planning" as being relevant to them; they are not usually planning a family. Contraception, birth control or youth advisory clinic may be terms easier to identify with.

Publicity is essential in setting up a centre if full use is to be made of it. It should be directed at both young people and the professionals caring for them. Posters, leaflets, articles in newspapers, professional journals and popular magazines read by teenagers, and radio and television are valuable in publicizing services, their location and opening times.

Referrals from health workers and other sources can be facilitated by "open house" meetings of local health staff, doctors, public health nurses, midwives, school, college and other educational representatives, social workers, youth workers, child care personnel and other interested workers. Given an opportunity to visit the centre, learn about the services offered and meet the staff, they may find it easier to refer young people they have recognized to be in need of contraceptive provision or counselling.

Contraceptive services tend to be female-orientated as the methods prescribed are usually used by the woman. Young men may feel they are not encouraged to be responsible or to use contraception. Where an effort is made to make them feel welcome at centres, both by the attitude of the staff and by the provision of some obviously male-orientated reading material, young men may attend both to accompany their partner and share in the consultations, or to obtain contraceptives (condoms) for themselves. They may use the opportunity to discuss their problems or sexual anxieties — a facility which is not readily available elsewhere.

In addition to clinic- and family doctor-based services, nonclinic-based counselling or informal youth advisory services may play an important role in contacting the nonconforming youngster who would not approach an authoritarian or clinical service. Once initial contact has been made and confidence established, direct personal referral to the clinical service can be made more successfully.

Where there is opposition to the provision of statutory services, it may be preferable for an independent or voluntary organization to set up pilot projects. If the work is monitored and evaluated, and reports are written for wide circulation to the health and education authorities and to the media for public dissemination, the need and the way of meeting it will be demonstrated and the pilot projects may provide a model for inclusion in national health services.

Obstacles to family planning services for young people

Where there are legal constraints on the provision of contraception for minors, and parental rights over children are paramount, the setting up of a service may not necessarily benefit the intended target group, since a considerable proportion will not use the service if it is conditional on parental consent.

If the local situation concerning pregnancy, abortion or incidence of sexually transmitted diseases has *not* been researched and the findings made known to policy-makers and the public, sympathetic support may not be forthcoming. Where termination of pregnancy is not legally available, provision of contraception becomes even more important.

In response to pressure from religious and traditionalist groups that oppose easier access, regulations and new interpretations have recently been introduced in some countries of the Region that have made it harder for young people, who know they are at risk and would benefit from contraception, to be seen using the services.

In some areas the medical profession does not give family planning high priority if it does not value it as a preventive health measure or if it finds it medically uninteresting and unchallenging. Financial considerations have been known to be an obstacle if the practitioner gains a proportion of his income from terminating pregnancies and providing private services, or on the other hand if he fears that he will lose the family as patients if he antagonizes the parents by providing birth control for their children.

There are many obstacles within the target group, including lack of knowledge and of factual information. There may also be fear of services and medical procedures, myths about the safety of available contraceptive methods, and even difficulty in accepting the fact of a sexual relationship. Obstacles to the provision of family planning can be identified under the same categories as those for sex education.

Obstacles within society

Legal

— Age of consent, age of consent to medical treatment, age of majority
— Contraception and its provision
— Abortion and its availability

Cultural

— Parental opposition
— Religious opposition
— Cultural and religious nonacceptability of certain methods

— Lack of understanding or acceptance of adolescent lifestyles
— Lack of public awareness of the problems

Socioeconomic

— Medical insurance systems excluding young people
— Health services budget limitation
— Demographic issues, pronatalist or antinatalist government policy
— Government policies regarding services — centrally funded or independent
— Low priority given to adolescents
— Low priority given to family planning in general

Obstacles within the service system

— Restrictive laws and regulations
— Lack of knowledge among service personnel
— Negative attitudes of staff to young people's sexuality
— Lack of facilities, trained personnel, funds, etc.
— Lack of anonymity, uncertainty about confidentiality
— Excessive fees for adolescents
— Lack of appropriate information
— Lack of contraceptive methods acceptable to adolescents or providers
— Geographical inaccessibility
— Unsuitable opening hours
— Lack of sufficient data for planning
— Lack of appropriate training programmes
— Low medical priority of family planning

Obstacles within the target group

— Resistance to the idea of contraception
— Lack of knowledge about availability and use of services
— Lack of trust in the services provided
— Lack of forward planning
— Resistance to planned use of contraception
— Fear of side effects of contraception
— Fear of medical examination

— Peer pressure
— Attitudes of adolescent males and females towards responsibilities
— Adolescent tendencies toward risk-taking behaviour, social revolt, etc.
— Sexual stereotyping (mass media influence)
— Wish for a child

DEVELOPMENT OF SEX EDUCATION PROGRAMMES

Development of curricula

Programmes are most effective if they have the support of the education authorities and if time is given to deciding what factual matter should be included to give adequate knowledge of mental, physical and emotional factors, and how responsible attitudes towards sexuality could be developed. It is important to stress the positive values of an understanding of the nature of sexuality and its significance in responsible human relationships, and to stress the equality of the sexes despite their different roles.

Sex education that is integrated throughout the school curriculum from preschool level to primary school and secondary school is preferable to a single course of instruction in the final year. By that time much information, possibly inaccurate, will have been acquired, and anxieties and ignorance about sexual matters will not have been relieved.

Three stages in the development of a sex education programme were described.

— Existing curricula in all subjects taught at school were studied and evaluated to determine to what extent the subject could be incorporated.

— Pilot studies were implemented, introducing experimental curricula into selected schools for evaluation.

— Final curricula were developed and are to be evaluated.

There would be a great variation in planning programmes for different areas that would reflect social conditions and expectations. For example, in a more liberal setting, marriage would be less important and the frequency of the single-parent family would be recognized, whereas in more conservative areas sexual behaviour could only be discussed within a marital context.

A basic core of information should be included, adapted to different age groups. The content could be repeated at different levels of child/adolescent development, since different questions would be asked, but information given should not be more than is asked for at any stage.

The curriculum should include information about the male and female body and its functions, changes that occur at puberty and the variations in both the timing of the event and in outcome of physical development that might lead to anxiety. Reproduction, conception and contraception, pregnancy and childbirth would be included. An understanding of the sexual spectrum and the place of homosexuality, masturbation and sexually transmitted diseases should not be overlooked.

Sex education should be part of a broader programme (e.g. "healthy lifestyles", "preparation for adulthood") that builds an understanding of the moral values needed to provide rational bases for making decisions, develops objective and understanding attitudes towards sex in its various manifestations, and fosters an appreciation of the positive satisfactions that honest and considerate relationships can bring.

Training of staff

For optimal effect, the training of educators should begin early, before sex education programmes are introduced into schools.

Inclusion of sex education in teacher-training curricula will give basic knowledge and awareness of the input of the programmes, as well as making the young teachers more understanding of their own sexuality, that of other people, and their differing views.

Not every teacher will elect to become a sex educator, or be effective if trained. Sex education is unlike education in general in that it directly, or in a very personal way, relates to the decisions people make about their lives. It is important to be sensitive to and to respect the privacy of both the educator and the student.

Training should include knowledge of the basic facts of human sexuality and an understanding of developmental, psychological and social factors, but should also provide a setting for the acquirement of the communication skills needed to transmit that knowledge, and develop empathy and understanding of the needs of the students. Sex educators should be given the opportunity to develop an awareness of their own sexuality, its needs and expression, and recognize their particular inhibitions and areas of discomfort. Various techniques were suggested to facilitate this type of training, rather than didactic teaching.

For example, the use of small group discussions could be explored, where questionnaires on different aspects of sex education are used to initiate discussion on sexual matters. A series of case histories presenting different situations can be used as a starting point for discussion of feelings

about any particular behaviour or practice to allow clarification of attitudes. In this way the privacy of the participants is respected, and they gain experience in discussing sexual matters and attitudes and learning from the views of others.

Role playing increases the understanding of other views and is a useful technique in studying attitudes.

Familiarity with sex education material and audiovisual aids should be acquired, and the development of material suitable for the target group and the culture should be encouraged.

There should be a commitment to continuing education both for updating and for increasing skills, and this should be met by inservice training.

The use of language in sex education was discussed. It was agreed that there may be discomfort or opposition to the use of vulgar or colloquial expressions for bodily functions and sexual parts, but it was recognized that, without an understanding of the nonmedical terminology, communication would be difficult. It was felt appropriate to acknowledge and be familiar with these terms, but to introduce and familiarize students with less emotive and acceptable language that would enable them to talk about sexual feelings and functions more freely.

Sex educators are not only teachers — they may be social workers, youth workers, members of the peer group, or belong to the health professions. They would all benefit from specific training in sex education.

Implementation of programmes

Parental influence can vary from being completely prohibitive and discouraging any consideration of sexual matters, to allowing sexual expression only within marriage, to being understanding and supportive of a young person's sexuality and encouraging sex education. Many parents are unaware of the changing pressures that their children face and their concepts of the problems may be quite irrelevant to their children's life. They may express relief that another agency such as the school is taking the responsibility, or may regret their own inability to play a more useful role particularly in the early years of childhood. Many parents would welcome further education to enable them to be more informed and helpful to their children, and it was agreed that both radio and television programmes directed towards adults could give them better information and support in this role. During adolescence there may be a need for privacy between parents and their offspring, and another adult such as an aunt, uncle or older person may be a more acceptable confidant to the young person.

Magazines and newspapers read by young people could be a useful source of information, and material presented on film and television, and more recently on video, has a wide impact. Values portrayed in the media

and in popular culture and music might not be those that would encourage stability and social responsibility, but they could be used as examples to discuss the values portrayed and assess such attitudes.

Other agencies involved in family planning have become involved in sex education. Partly as a result of this, there has been a shift in emphasis of both content and methodology of sex education where programmes have been in use for some years. To begin with, teaching was formal and subjects were introduced according to the medical model, concentrating on reproduction. Educators were often medical personnel.

Specialists now offer their skills to teachers and other professional educators, and prefer not to attend a school for a single session that is usually devoted to contraception and sexually transmitted diseases and is held just before school-leaving age. There is also more emphasis now on personal relationships and sexuality, which is perceived as more than sexual intercourse. More attention is paid to the importance of sexuality as a value in itself and in a social context. The format of teaching has changed from the single "lecture" to an integrated programme, or series of visits, and the method of education has changed. In place of the didactic lecture there is greater use of participatory techniques, such as role playing and the use of quizzes, and particularly in the older age groups there is a preference for small group discussions in which the teacher acts as a facilitator to encourage expression of opinion that allows the students to talk about matters that directly concern them.

There are some schemes whereby young volunteers have been trained as reliable conveyors of information to their peer groups, and have been able to refer those in need to the appropriate service. This is most effective for groups that have left school and may have had inadequate sex education, and who are sexually active but not confident in approaching established medical services for advice. There is a high turnover rate of young volunteers because of their educational or employment commitments, and the system of training has to be continuous, but the long-term effect is beneficial in producing an increasing number of informed individuals who continue to act as resource and referral advisers to their peers.

Telephone answering services are provided by some family planning agencies. These are widely used to give information on factual matters such as provision of services, use of contraceptives, etc. Also, because of their anonymity, they are preferred by many young people concerned about their sexuality or sexual relationships and wishing to discuss them with an informed person.

Some groups of young people are particularly vulnerable, and liable to be overlooked in sex education programmes. One such group are migrants, who may have to adjust to different cultural practices and expectations

which may conflict with their upbringing. The identification and training of suitable members of a migrant community to act as links and interpreters is important in dealing with this problem.

Another group likely to be overlooked comprises the physically or mentally handicapped, particularly if they are isolated in particular educational institutions or hospitals catering for their disability, or are confined to their homes. This may be due to a reluctance to recognize the sexuality of handicapped people and their need of expression. In some areas programmes have been established to educate those caring for the handicapped so that they can provide sex education and recognize the sexuality of those they care for and provide for its expression.

Nonmedically-based counselling services for young people are particularly important. Their informal, open-door approach and use of trained counsellors has allowed them to be used as an alternative source of information, and by young people who are uncomfortable with established services. Although they deal with a variety of problems, including homelessness, loneliness and drug and alcohol abuse, a number of the young people they see may have problems related to their sexuality that require understanding and counselling.

The role of libraries accessible to young people in providing books on sexual matters should not be overlooked. This is a popular and important medium of sex education in matters that are of particular concern to the individual.

DEVELOPMENT OF FAMILY PLANNING SERVICES FOR YOUNG PEOPLE

Sex education by itself neither prevents nor promotes sexual activity in young people. The provision and use of contraception should be given priority if pregnancies in young women are to be reduced and young people are to be able to express their sexuality without unnecessary fears. This is obviously easier in those countries where family planning services are already established, but there is a need for services to include this particularly vulnerable group in areas where provision is still being developed.

Experience shows that the beneficial effects of providing services, as indicated by pregnancy rates in the target group, takes from 3 to 10 years to become apparent. This reflects initial hesitation — particularly before possible pregnancy makes consultation necessary — until the service is accepted with confidence and can be used before or early in a sexual

relationship, as much early sexual activity is unpremeditated and may not be within an established relationship. Where adequate services are provided, national rates of pregnancy that end in birth or abortion have shown a decline over the years. Where abortions are legal, the birth rate may be reduced initially by increasing use of abortion, but as the use of contraceptive services increases there is a reduction in the total pregnancy rate and a corresponding reduction in the abortion rate. This has been noted particularly where the sex education programme has stressed the responsibility of both partners. An awareness of the hazards of sexually transmitted diseases has led to an increased acceptance and use of the condom early in relationships. However, most young people still make their first contact with a service-providing unit when they think they might already be pregnant.

With increasing knowledge and availability in some countries of post-coital contraception that can be used up to 72 hours after intercourse, more young people are presenting themselves after unprotected coitus. This may result in a decreasing number of abortions, but is also important in establishing contact with a service which, if acceptable, will allow discussion and provision of future contraception.

The place of family planning services for young people in the health service structure

To ensure the widest coverage, services should be provided at a number of outlets, both integrated into the existing services and by setting up special services aimed at the target group. This would also allow some choice on where to go for advice, an important factor if services are unacceptable in a particular setting, usually due to lack of empathy with the provider or a fear of lack of anonymity.

Integrated services

Integrated services include family doctors or general practitioners who are willing to provide contraception, maternal and child health clinics and other community-based services, school health services, and outpatient clinics attached to hospitals. Where services are integrated and use the same premises, they can be made more readily acceptable by providing a special service for young people at different hours, and/or by using different staff who are sympathetic to the needs of the young.

Where there is full integration with services for adults, there may be anxiety about reception and anonymity. However, where only an integrated service is provided a large proportion of the target group will not come forward if a special approach is not offered.

Special services for young people

There is a variety of services for young people which have an important role to play in the provision of contraception.

— Adolescent clinics have been established in some areas to counsel young people on medical and general problems; sexual and reproductive aspects are also dealt with.

— Student health services attached to universities and colleges of further education can be, and often are, used to provide contraceptive advice.

— Contraceptive clinics for young people allow an approach that is directed at the target group, and is recognized by them as being prepared to offer help, so that initial reluctance to attend may be lessened.

The special service units also have a role as a training facility for staff who may then work in the integrated services, and in this more flexible setting can test and evaluate new approaches.

Services for young people should respond to the needs of their local target group and to changes in the group, such as the presence of new immigrants. They should also be prepared to provide new services if a need becomes apparent, for example screening for rubella, infection testing, or pregnancy counselling.

Where different services are provided for young people, the value of an advisory or coordinating committee to exchange information and ideas at local as well as national levels is important. Such a committee should include representatives from the social and educational services, youth workers and service providers. The possibility of including representatives of local young people, so as to allow them to present their views, should be considered.

Sexually active young people from rural areas often have no access to a central service. In rural areas in many countries, early pregnancy usually results in marriage. Priority there could be given to the training of midwives as providers of contraception, as they are usually local people.

Roles and training of staff

In providing family planning services for young people the attitudes of the providers are crucial. Those responsible for the organization and planning of services, decision-makers, politicians, administrators, local authority officials, and the professionals directly involved should therefore understand the importance of family planning for the self-esteem, physical and mental health, and future life of young people. They should understand the

special needs and difficulties of young people seeking advice about sexuality and contraception.

The type of service offered and the personnel employed may depend on the sources of funding and not only on the intention of the service unit, for example within an integrated health service unit staff may be assigned who have no particular interest in family planning or young people. Reception staff, physicians, nurses and midwives may then be confined to traditional roles.

General practitioners and gynaecologists have mostly been responsible for prescribing modern contraceptive methods such as oral contraceptives and intra-uterine devices (IUDs). Where they have not had any special training their interest may be mainly technical, and they may give family planning a low priority if it is not felt sufficiently challenging.

Until family planning and its implications and consequences can be introduced into the undergraduate medical curriculum, provision should be made for special training of doctors in the techniques and skills required, particularly if they are to work with young people.

As the psychosocial aspects are so important in dealing with young people, other categories of health and social service personnel should be included and trained to provide services. Nurse/midwives are particularly suitable. From their professional training they are accustomed to providing health care, and as they are usually women they may relate more easily to young girls. With extra training nurse/midwives can become providers of contraceptive care, including prescribing oral contraceptives and inserting IUDs. Where this has been done, it has been found that their approach, knowledge and involvement with local people makes them highly acceptable by the target group, and that the standard of medical care is maintained.

Doctors can then be used as instructors, and for referral and consultation in certain difficult cases that the nurse/midwife has been trained to recognize. The use of nursing personnel as chaperons for doctors and for clerical duties is an extravagant use of personnel.

Services are better coordinated when the unit works as a team that has a common recognized goal — to provide the most acceptable service for the young person — and when each member of the team understands his/her own role and accepts that of others as complementary.

Inservice training is extremely important. Training will vary for different categories of staff, but there will be some factors in common. There are various requirements in the provision of inservice training.

— A handbook or manual should be available for reference and as a means of updating both procedure and contraceptive technology. It would outline the aims and purpose of the unit with which it would

expect the staff to be in sympathy, for example a willingness to give young people contraception advice.

— Training in communication skills should be given; this could include the use of role playing to gain experience of working with clients.

— Group meetings should be held to give experience in discussing sexual matters, gain understanding of staff members' own sexuality, and examine their personal/cultural values. This would lead to greater understanding of the sexual morality and traditions of different religious, social and ethnic groups. Where staff members have a varied national and ethnic background, they can contribute to the exchange of knowledge.

— Working alongside an experienced colleague would facilitate training.

— Regular staff meetings should be held. The purpose of such meetings would be to discuss management of the service, case-work and any conflicts that arise between staff, or complaints from clients.

— Weekday or weekend meetings could be held for updating. Professional staff would be expected to attend professional meetings and read the relevant journals.

Service acceptability and the client

The following criteria are proposed to encourage attendance.

Publicity. It is essential that available services are widely publicized to encourage maximum utilization.

Reception. Initial contact either by telephone or with reception staff must be welcoming if young people are to feel encouraged to attend.

Access. The centre should be geographically situated where there is easy access, either on foot or by public transport. Directions should be clear on informative literature, and signposting should be easily visible.

Hours of opening. These should be adapted to the needs of young people. If it is not possible to provide daily opening, the early evening and/or Saturday mornings might be suitable for those in education or employment. In a busy service it might not be possible to allow open access without long queues building up, but there is a need for young people to be seen when they arrive, i.e. when their motivation is strong, particularly if

there is the possibility of a pregnancy or a request for post-coital contraception. A combination of open access and appointments would allow best use of personnel, but flexibility is important.

Confidentiality. This must be respected by all members of the service. Clients should appreciate that no information will be given to anyone or any other agency without their permission.

Credibility. It should be established that the service has a positive attitude to the sexuality of young people.

Milieu. Given a choice, an informal setting is preferable to a clinical one. It should allow for groups of young people coming for mutual support and to view the centre. Music may be provided in the waiting areas, providing some background cover when confidential information is being exchanged. Drinks or snacks may be available while clients wait.

The staff team. The team should be motivated to work with young people, and be prepared to continue with inservice training.

Complaints. There should be established channels to deal with complaints from clients or staff. Complaints should be followed up to check deficiencies in service or personnel, and action taken to correct them.

Types of service. The services provided will vary according to different settings and local demand, but the following have priority.

— Contraceptive provision should include the widest variety of methods available, and include oral contraception, IUDs, barrier methods such as diaphragms, condoms and spermicides, and instruction in natural methods of family planning when requested.

— A pregnancy testing service is necessary, particularly one that uses a method that can be employed at the centre, and the result obtained in a short time so that appropriate action may be taken. Other services may include pregnancy counselling and the decision of its outcome, to continue or refer for abortion where possible.

— Psychosocial problems will present in the family planning services and trained personnel should be provided to deal with them.

— General counselling on other aspects of growing up may be provided, and the inclusion of a trained counsellor or social worker in the team is of great benefit.

— Infection testing is valuable if there are the laboratory facilities for bacteriology and referral to other services is not deemed suitable. Screening of young women for immunity to rubella can be included, and sometimes early treatment of subfertility and advice on preparation for parenthood may be given.

CONCLUSIONS AND RECOMMENDATIONS

Education

Guidelines for educational programmes

General principles

1. Sexuality in sex education programmes is often presented in a negative fashion; it should be portrayed in a positive manner with the emphasis on understanding, mutual tenderness, delight and responsibility.

2. The young people's own concerns about their sexuality should be considered in planning sex education programmes and disseminating information, and the value of peer groups should not be neglected.

3. Research is an important tool in changing attitudes and creating public and official awareness of problems.

Recommendations

1. There should be further research into adolescents' own perception of their needs in sex education and better dissemination of research findings, which can be done through clearing-houses and other mechanisms, in order to raise the level of public and official awareness.

2. Guidelines for sex education programmes and for sex educators should be laid down in written form by each individual programme designer according to local situations, so as to provide a framework to safeguard the dignity and integrity of both student and teacher.

3. Sex education should be age-specific, beginning early in life before school age. In this, parents play a crucial role. Channels should be developed to give parents the appropriate knowledge and skill to give information and educate their children.

4. As the emphasis in sex education is frequently focused on reproductive practice and consequences, and is directed at girls, more emphasis should be given to the roles and responsibilities of both sexes.

5. Sex education must be an integral part of education in every school system, to be implemented before puberty and enforced by legislation.

Content of educational programmes

Recommendations

1. The basic content of every sex education programme will be information on human anatomy, reproductive physiology, family planning and emotional aspects.

2. Owing to the various cultural and socioeconomic conditions in different countries, the content of sex education programmes should be tailored to meet individual requirements, but will contain basic information on human anatomy, reproductive physiology and family planning.

3. Since little written/audiovisual material is aimed specifically at adolescents, a greater variety of educational target-group material should be produced.

4. The ways in which sexuality and sexual relations are portrayed in the popular media and advertisements should be considered in all sex education programmes, stressing the importance of equality between the sexes and the emotional aspects of sexual relationships.

Educational staff and their training

General principles

1. The minimum requirement for a good sex educator is a basic knowledge of the facts concerning human sexuality, proficiency in communication skills, and experience of group work.

2. In order that sex education can be taught with empathy, sex educators should be specially trained over and above their basic qualification.

3. Sex educators should be willing to continue and update their training. This can be facilitated by inservice training.

Recommendations

1. Ministers of education and of health should ensure that training in sex education is included in the basic content of all training programmes for teachers and health professionals.

2. Teachers who are currently working in sex education programmes must be given additional training.

3. Institutions providing sex education training should offer continuous revision courses and inservice training, and sex educators should be willing and encouraged to attend these courses.

Services

Guidelines for the provision of family planning services for young people

General principles

1. Sex education is not really effective if there is no family planning service to back it up.

2. Since cultural and socioeconomic settings vary, adolescent service models will vary accordingly.

3. A guarantee of confidentiality is essential before adolescents can feel confident to make use of the service, and no information should be disclosed without their express permission. However, they should be encouraged to discuss the situation with their parents.

4. The credibility of services for young people depends largely on the supportive attitudes of staff towards adolescent sexuality.

Recommendations

1. To make family planning accessible to young people, legal obstacles should be removed. It is the duty of concerned organizations, individual professionals and groups to work towards this end.

Organization and setting of family planning services for young people

General principles

1. A successful service usually displays the following characteristics: it is well publicized; it is geographically accessible with convenient opening

hours; it has a welcoming and informal atmosphere; and the staff are selected for their suitability in working with young people.

2. Experience has shown that initial contact between services and adolescents is often the result of feared pregnancy.

Recommendations

1. Governments should recognize and ensure appropriate funding for the establishment of family planning services offered to young people.

2. All services for young people should provide pregnancy testing.

3. Pilot services should be set up and supported at local level to provide a model for the national level.

4. Centres that do not offer comprehensive services should have established channels for referring clients to the relevant services.

5. For overall coverage it is necessary to depend on adolescent services integrated within a comprehensive family planning network, but it is recognized that separate additional services will always be essential.

6. Provision of services should be adaptable to meet changing needs.

7. Services for young people should be provided by multidisciplinary teams.

Staff and their training

General principles

1. Personnel should be supportive towards adolescent sexuality and the provision of specific family planning services for adolescents.

2. An understanding of and acceptance of the sexuality and cultural values of other groups is needed (such as sexual minorities, ethnic and religious groups, and the physically and mentally handicapped).

3. Owing to the nature of the work, it is important that individual staff members feel at ease with their own sexuality.

4. It is important that the different categories of staff recognize and agree on each other's roles and acknowledge the importance of each other's contribution to achieve a common goal.

5. Nurse/midwives and pharmacists are often an overlooked resource in delivering family planning services.

Recommendations

1. Staff working with young people within integrated family planning services and separate young people's services should have some special training in understanding adolescent sexuality and behaviour.

2. During training, personnel should be made aware of their own cultural values and sexuality so that they may be more sensitive to differences in others.

3. Inservice training, including continued support and updating, should be provided for all categories of staff.

4. Training for providing family planning for young people should encompass not only the medical aspects but should include psychological, social and emotional factors.

5. Midwives and suitable nurses should be trained for the delivery of all kinds of contraceptive service. Where legal barriers prevent such a role, these obstacles should be removed.

General recommendations

1. There should be coordination at national and local levels between departments of health and education and other concerned bodies in the provision of sex education and family planning services.

2. There should be greater collaboration at the international level between relevant bodies (intergovernmental and nongovernmental organizations) engaged in research on sex education and services for young people.

Annex 1

LIST OF PARTICIPANTS

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RESUME

Introduction

La réunion a été suivie par onze conseillers temporaires dont un de l'Organisation des Nations Unies pour l'Education, la Science et la Culture (UNESCO) et un de la Fédération internationale pour le Planning familial (IPPF). Parmi les disciplines représentées figuraient l'éducation, la psychologie, la pédiatrie, la démographie, l'obstétrique et la gynécologie, la planification familiale et la médecine psycho-sexuelle.

La réunion faisait suite à une étude sur la planification familiale et l'éducation sexuelle des adolescents effectuée en 1981 par le service de la planification familiale. Le projet de rapport de cette étude, qui présente de manière critique les stratégies appliquées dans divers pays pour fournir aux adolescents des services de planification familiale et d'éducation sexuelle, a servi de document de base pour le groupe de travail.

Discussion

Les participants ont examiné les obstacles qui s'opposent dans plusieurs pays à l'éducation sexuelle et à la fourniture de services de planification familiale aux adolescents.

Ils ont étudié les conditions de l'élaboration des programmes d'éducation sexuelle en mettant l'accent sur les contenus de ces programmes, la formation du personnel et la mise en œuvre des programmes. Ils ont également étudié la création de services de planification familiale pour les adolescents en insistant notamment sur les rôles du personnel et sur sa formation ainsi que sur la fourniture de services acceptables pour le groupe cible.

Recommandations

Education

Directives pour les programmes éducatifs

1. Il faudrait étudier de manière plus approfondie la conception qu'ont les adolescents de leurs besoins en matière d'éducation sexuelle et diffuser plus largement les résultats de ces recherches, par le biais de bureaux de centralisation des informations ou de tout autre moyen, afin de sensibiliser davantage le public et les responsables.

2. Des directives pour l'élaboration des programmes d'éducation sexuelle et à l'intention des éducateurs sexuels devraient être rédigées par les différentes personnes compétentes, en fonction des conditions locales, et fournir ainsi un cadre permettant de protéger la dignité et l'intégrité tant de l'étudiant que de l'enseignant.

3. L'éducation sexuelle devrait être adaptée à l'âge et débuter tôt dans la vie, avant l'âge scolaire, quand les parents jouent un rôle crucial. Il faut pouvoir fournir aux parents les connaissances et les moyens nécessaires pour informer et éduquer leurs enfants.

4. L'éducation sexuelle étant souvent axée sur la reproduction et ses conséquences, et destinée aux filles, il faudra souligner davantage à l'avenir les rôles et les responsaiblités des deux sexes.

5. L'éducation sexuelle devrait faire partie intégrante de l'éducation dans tous les systèmes scolaires. Elle devrait avoir lieu avant la puberté et être rendue obligatoire par la législation en vigueur.

Contenu des programmes éducatifs

6. Etant donné que les conditions culturelles et socio-économiques varient selon les pays, le contenu des programmes d'éducation sexuelle devrait être conçu en fonction des besoins individuels, tout en contenant des informations de base sur l'anatomie humaine, la physiologie de la reproduction, la planification familiale et les aspects émotionnels.

7. Comme il existe peu de programmes éducatifs audiovisuels destinés spécifiquement aux adolescents, il faudra en accroître la production.

8. Tous les programmes d'éducation sexuelle devraient tenir compte de la façon dont les grands moyens d'information et la publicité décrivent la sexualité et les relations sexuelles et insister sur l'importance de l'égalité entre les sexes et sur les aspects émotionnels des relations sexuelles.

Le personnel enseignant et sa formation

9. Les ministères de l'éducation devraient veiller à l'inclusion de la formation à l'éducation sexuelle dans tous les programmes de formation de base des enseignants et des professionnels de la santé.

10. Les enseignants qui appliquent déjà des programmes d'éducation sexuelle devraient recevoir une formation complémentaire.

11. Les établissements qui donnent une formation en éducation sexuelle devraient offrir des cours permanents de mise à jour et de formation en cours d'activité; les éducateurs sexuels devraient être disposés à suivre ces cours et y être encouragés.

Services

Directives pour la fourniture de services de planification familiale aux adolescents

12. Afin de rendre la planification familiale accessible aux adolescents, les obstacles juridiques doivent être levés. Les organisations, les différents professionnels et les groupes concernés ont le devoir d'agir en ce sens.

Organisation et mise en place de services de planification familiale à l'intention des adolescents

13. Les gouvernements devraient reconnaître la nécessité de créer des services de planification familiale pour les adolescents et veiller à ce que ces services disposent de moyens financiers suffisants.

14. Tous les services pour les adolescents devraient fournir les moyens de diagnostiquer une grossesse.

15. Des services pilotes d'appui pour adolescents devraient être créés et aidés au niveau local afin de servir de modèle pour le niveau national.

16. Les centres qui ne proposent pas tous les services devraient diriger leurs clients vers les centres compétents.

17. Afin d'assurer une couverture d'ensemble, il faut que les services pour adolescents soient intégrés dans un réseau général de planification familiale, mais des services distincts complémentaires auront toujours un rôle essentiel à jouer.

18. Les services fournis devraient pouvoir suivre l'évolution des besoins.

19. Les services pour adolescents devraient être fournis par des équipes pluridisciplinaires.

Le personnel des services de planification familiale et sa formation

20. Le personnel travaillant avec les adolescents soit dans les services intégrés de planification familiale, soit dans les services indépendants pour adolescents, devrait recevoir une formation spéciale lui permettant de comprendre la sexualité et le comportement des adolescents.

21. Pendant la formation, il faudrait faire prendre conscience au personnel de ses propres valeurs culturelles et de sa sexualité, afin qu'il soit plus réceptif à l'égard des différences qui existent chez les autres.

22. La formation en cours d'emploi, y compris les enseignements permanents de soutien et de mise à jour, devrait être assurée à l'intention de toutes les catégories de personnel.

23. La formation à la fourniture de services de planification familiale pour les adolescents devrait recouvrir non seulement les facteurs médicaux, mais également les facteurs psychologiques, sociaux et émotionnels.

24. Les sages-femmes et les infirmières devraient être formées en vue de fournir tous les moyens de contraception. Si des obstacles légaux s'y opposent, il faudrait les lever.

Généralités

De nombreux éléments, en matière d'éducation sexuelle et de planification familiale, se recoupent ou sont complémentaires. En conséquence :

25. il faudrait instaurer une coordination à l'échelon national et local entre les départements de la santé et de l'éducation et les autres organismes concernés par l'éducation sexuelle et la fourniture des services de planification familiale;

26. il faudrait développer la collaboration internationale entre les organisations intergouvernementales et non gouvernementales intéressées, engagées dans des activités similaires et qui font de la recherche dans le domaine de l'éducation sexuelle et des services pour les adolescents.

Les participants à la réunion ont estimé qu'il serait souhaitable de compléter le rapport du groupe de travail par plusieurs études sur le terrain, dans différents pays, et d'organiser une réunion pour réexaminer la situation dans trois ou quatre ans.

ZUSAMMENFASSUNG

Einleitung

An der Arbeitsgruppe nahmen 11 Berater auf Zeit teil, darunter ein Berater der Organisation der Vereinten Nationen für Erziehung, Wissenschaft und Kultur (UNESCO) und ein Berater der International Planned Parenthood Federation (IPPF). Zu den vertretenen Fachbereichen gehörten: Erziehungswissenschaften, Psychologie, Pädiatrie, Demographie, Geburtshilfe und Frauenheilkunde, Familienplanung sowie Psychosexualmedizin.

Die Tagung fand zur Aktualisierung der Studie über Familienplanung und Sexualerziehung Jugendlicher, die von der Abteilung für Familienplanung im Jahre 1981 durchgeführt worden war, statt. Der Entwurf des Berichts über diese Studie, in welchem die Strategien der verschiedenen Länder hinsichtlich der Umsetzung der Familienplanung und Sexualaufklärung Jugendlicher beschrieben und erörtert werden, diente als Grundlage für die Arbeitsgruppe.

Diskussion

Die Tagungsteilnehmer besprachen sich über die in einigen Ländern angetroffenen Hindernisse in bezug auf die Sexualerziehung und die Organisation der Familienplanungsdienste für Jugendliche.

Es wurde untersucht, inwieweit Sexualerziehungsprogramme unterstützt werden, wobei der Schwerpunkt auf den Aufbau von Lehrplänen, die Ausbildung der Mitarbeiter und die Durchführung der Programme gelegt wurde. Ferner wurde der Ausbau der Familienplanungsdienste für Jugendliche untersucht, und besondere Aufmerksamkeit wurde der Rolle und der Ausbildung der Mitarbeiter und der Umsetzung der von der Zielgruppe erwünschten Dienste gewidmet.

Empfehlungen

Erziehung

Richtlinien für Aufklärungsprogramme

1. Es müßten weitere Nachforschungen angestellt werden, um herauszufinden, welche Vorstellungen die Jugendlichen selbst über ihre Bedürfnisse in bezug auf Sexualerziehung haben, und die Ergebnisse dieser Untersuchungen müßten auf breiterer Basis bekanntgemacht werden, z.B. durch Informationsaustauschzentralen oder sonstige Einrichtungen, um diese Probleme in das Bewußtsein der Öffentlichkeit und der einschlägigen Dienststellen zu bringen.

2. Nach Maßgabe der örtlichen Voraussetzungen sollten die jeweiligen für die Programme Verantwortlichen schriftliche Richtlinien für die Sexualaufklärungsprogramme und für die Sexualerzieher ausarbeiten, um diesem Bereich einen Rahmen zu geben, der die Würde und Integrität sowohl der Schüler als auch der Lehrer wahrt.

3. Sexualerziehung sollte dem Alter angepaßt sein und im frühen Kindesalter (vor der Einschulung), in dem den Eltern eine wesentliche Rolle zufällt, beginnen. Es sollten Mittel und Wege gefunden werden, den Eltern das notwendige Wissen zu vermitteln, sowie die Befähigung, dieses Wissen an ihre Kinder weiterzugeben.

4. Bei der Sexualaufklärung wird häufig der Schwerpunkt auf den Zeugungsvorgang und dessen Folgen gelegt und meist werden nur die Mädchen einbezogen; es sollte jedoch die Rolle und Verantwortlichkeit beider Geschlechter unterstrichen werden.

5. Sexualaufklärung sollte in jedem Schulsystem ein integraler Bestandteil der Erziehung sein, vor der Pubertät erfolgen und gesetzlich vorgesehen werden.

Umfang der Aufklärungsprogramme

6. Wegen der unterschiedlichen kulturellen und sozialökonomischen Voraussetzungen in den verschiedenen Ländern sollte der Umfang der Sexualerziehungsprogramme auf die jeweiligen Bedürfnisse zugeschnitten sein, sie sollten aber grundlegende Informationen über die Anatomie des Menschen, den Zeugungsvorgang, Familienplanung und emotionale Gesichtspunkte beinhalten.

7. Da es kaum spezifische audiovisuelle Unterrichtsunterlagen für Jugendliche gibt, sollte eine größere Vielfalt an Lehrmaterial speziell für diese Zielgruppe ausgearbeitet werden.

8. Die Art und Weise, in welcher Sexualität und sexuelle Beziehungen in den Volksmedien und in Anzeigen dargestellt werden, sollte in allen Sexualerziehungsprogrammen Berücksichtigung finden, unter Hervorhebung der Bedeutung einer Gleichbehandlung der Geschlechter und emotionaler Gesichtspunkte.

Erzieher und deren Ausbildung

9. Die Unterrichtsministerien sollten sicherstellen, daß eine Unterrichtung in Sexualerziehung in die Grundausbildung im Rahmen jeglicher Berufsprogramme für Lehrer und Fachpersonal des Gesundheitswesens aufgenommen wird.

10. Lehrer, die Sexualkundeunterricht erteilen, sollten eine zusätzliche Ausbildung erhalten.

11. Institutionen, die eine Ausbildung in Sexualerziehung vermitteln, sollten fortlaufende Weiterbildungskurse und interne Lehrgänge anbieten, und Sexualerzieher sollten zur Teilnahme an derartigen Kursen bereit sein und dazu motiviert werden.

Einrichtungen

Richtlinien über Familienplanungsdienste für Jugendliche

12. Um den Jugendlichen Familienplanungsdienste zugänglich zu machen, sollten die gesetzlichen Hindernisse beseitigt werden. Es ist Aufgabe der betroffenen Organisationen, die Tätigkeit von einzelnen Fachleuten oder Berufsgruppen dahingehend auszurichten.

Organisation und Einrichtung von Familienplanungsdiensten für Jugendliche

13. Die Regierungen sollten sich über die Notwendigkeit der Einrichtung von Familienplanungsdiensten für Jugendliche bewußt werden und sicherstellen, daß die entsprechenden Geldmittel zur Verfügung gestellt werden.

14. Alle derartigen Einrichtungen für Jugendliche sollten Möglichkeiten für die Durchführung von Schwangerschaftsnachweisen bieten.

15. Zusätzlich sollten als Modell für Einrichtungen auf Landesebene örtliche Versuchszentren für Jugendliche geschaffen und gefördert werden.

16. Zentren, die keine umfassenden Dienste anbieten, sollten über Möglichkeiten verfügen, die Ratsuchenden an die entsprechenden Stellen zu verweisen.

17. Zur allgemeinen Erfassung ist es notwendig, daß die Einrichtungen für Heranwachsende integraler Bestandteil eines umfassenden Netzes für Familienplanung sind, es wird jedoch davon ausgegangen, daß Sondereinrichtungen als Zusatzdienste stets unbedingt erforderlich sind.

18. Das Dienstangebot sollte den sich ändernden Bedürfnissen angepaßt werden können.

19. Dienste für junge Leute sollten in Form von multidisziplinären Teams angeboten werden.

Mitarbeiter und deren Ausbildung

20. Personen, die entweder in integrierten Familienplanungsstellen oder in besonderen Einrichtungen für Jugendliche mit jungen Leuten arbeiten, sollten über eine Spezialausbildung verfügen, um Verständnis für die Sexualität und das Sexualverhalten Heranwachsender aufzubringen.

21. Während der Ausbildung sollte den Mitarbeitern ihre eigene Kultur und Sexualität ins Bewußtsein gebracht werden, damit sie dem unterschiedlichen Verhalten anderer aufgeschlossener gegenüberstehen können.

22. Für Mitarbeiter aller Kategorien sollten interne Lehrgänge einschließlich fortlaufender Förder- und Auffrischungskurse angeboten werden.

23. Die Ausbildung auf dem Gebiet der Familienplanungsdienste für Jugendliche sollte sich nicht nur auf die medizinischen, sondern auch auf die psychologischen, sozialen und emotionalen Gesichtspunkte erstrecken.

24. Hebammen und geeignetes Pflegepersonal sollten für die Durchführung jeglicher Art von Empfängnisverhütungsmaßnahmen ausgebildet werden. Wo dies aufgrund gesetzlicher Bestimmungen nicht möglich ist, sollten derartige Hindernisse abgebaut werden.

Allgemeines

Auf den Gebieten Sexualerziehung und einschlägige Dienste gibt es viele Überschneidungen und Doppelgleisigkeiten. Deshalb sollte es:

25. auf nationaler und lokaler Ebene eine Koordination zwischen den Gesundheits- und Unterrichtsministerien sowie den anderen zuständigen Stellen hinsichtlich der Sexualerziehung und Familienplanung und

26. auf internationaler Ebene zwischen den einschlägigen mit diesen oder ähnlichen Aufgaben befaßten nichtstaatlichen und zwischenstaatlichen Organisationen eine engere Zusammenarbeit und Forschungstätigkeit im Bereich der Sexualerziehung und dazugehörigen Dienste für Jugendliche geben.

Die Tagungsteilnehmer hielten es für angebracht, den Bericht dieser Arbeitsgruppe durch verschiedene Feldstudien in mehreren Ländern zu ergänzen und in drei bis vier Jahren eine neue Tagung abzuhalten, um die Lage zu überprüfen.

РЕЗЮМЕ

Введение

В работе данного совещания приняли участие одиннадцать временных советников, в том числе один представитель ООН по вопросам образования, науки и культуры (ЮНЕСКО) и один представитель Международной федерации обществ регулирования численности народонаселения (МФОРЧН). Среди участников совещания были специалисты в области образования, психологии, педиатрии, демографии, акушерства, гинекологии, планирования семьи и психосексуальной медицины.

Совещание было организовано в развитие исследования, посвященного вопросам планирования семьи и полового воспитания молодежи, проведенного в 1981 г. подразделением по планированию семьи. Исходным документом совещания служил проект отчета об исследовании, содержащий материалы дискуссии и описание стратегий, используемых в различных странах при осуществлении деятельности по планированию семьи и половому воспитанию молодежи.

Дискуссия

На совещании были проанализированы препятствия, которые встречаются в различных странах при организации полового воспитания молодежи, а также служб планирования семьи, предназначенных для этого контингента.

Были рассмотрены вопросы разработки программ полового воспитания, при этом основное внимание было уделено составлению учебных программ, подготовке персонала и осуществлению программ. Были также рассмотрены вопросы создания служб планирования семьи для молодежи, при этом особое внимание было уделено функциям и подготовке персонала, а также вопросам организации служб, доступных для этой целевой группы.

Рекомендации

Обучению

Указания по составлению програми обучения

1. Необходимо продолжить изучение вопроса о том, как сама молодежь оценивает свои потребности в половом воспитании, шире распространять результаты научных разработок, используя для этого банки данных или другие механизмы, с тем, чтобы повысить уровень осведомленности населения и официальных органов о состоянии дел в этой области.

2. Составители отдельных програми должны с учетом местных условий подготовить в письменном виде указания по программам полового воспитания, а также указания для специалистов по половому воспитанию, цель которых - обеспечить соответствующую этическую основу взаимоотношений между студентом и преподавателем.

3. Для каждой возрастной группы должна быть разработана отдельная программа полового воспитания. Начинать его надо в раннем возрасте до поступления детей в школу, т.е. в период, когда роль родителей особенно велика. Необходимо определить механизмы, которые позволяли бы родителям получать знания и навыки, необходимые для информирования и воспитания детей.

4. Поскольку сейчас основное внимание в половом воспитании нередко уделяется вопросам, связанным с воспроизводством и его последствиями, а также в связи с тем, что такого рода воспитание в основном проводится среди девочек, следует делать больший упор на роль и ответственность обоих полов.

5. Половое воспитание должно стать составной частью програми обучения в каждой школе, осуществляться до наступления периода половой зрелости и должно быть закреплено в законодательном порядке.

Содержание программ обучения

6. Содержание программ полового воспитания должно отвечать конкретным культурным и социально-экономическим условиям различных стран; однако при этом следует предусмотреть включение в эти программы основополагающей информации по вопросам анатомии человека, физиологии воспроизводства, планирования семьи, а также по эмоциональным аспектам.

7. Учитывая незначительный объем видео-звуковых материалов, подготовленных специально для молодежи, необходимо увеличить выпуск различных учебных материалов для данной целевой группы.

8. В рамках всех программ полового воспитания необходимо анализировать методы, используемые наиболее популярными средствами массовой информации и рекламой, при отображении явлений жизни, связанных с сексуальностью и половыми отношениями; при этом особое внимание должно быть уделено проблемам равенства полов, а также эмоциональным аспектам половых отношений.

Преподавательский состав и его подготовка

9. Министерства образования должны обеспечить включение вопросов подготовки в области полового воспитания в основные программы обучения всех преподавателей и медработников.

10. Дополнительную подготовку должны пройти преподаватели, которые осуществляют практическую деятельность по программам полового воспитания.

11. Учреждения, в которых осуществляется подготовка в области полового воспитания, должны организовывать постоянные курсы повышения квалификации и учебу без отрыва от производства, а преподаватели в области полового воспитания должны стремиться к учебе на таких курсах, для чего следует разъяснять им необходимость посещения курсов.

Указания по организации служб планирования семьи для молодежи

12. Чтобы службы планирования семьи были доступными для молодежи, необходимо устранить препятствия юридического характера. Достижение этой цели является задачей соответствующих организаций, отдельных профессиональных работников и групп.

Организация и создание служб планирования семьи для молодежи

13. Правительства должны признать необходимость создания служб планирования семьи для молодежи и обеспечить выделение необходимых для этого средств.

14. Все службы планирования семьи для молодежи должны проводить анализы для установления беременности.

15. Необходимо создавать вспомогательные экспериментальные службы для молодежи и оказывать им поддержку на местном уровне; это позволит разработать модель подобных служб для использования на национальном уровне.

16. Центры, не располагающие комплексными службами, должны разработать систему направления пациентов в соответствующие службы.

17. В целях охвата всего населения в первую очередь необходимо интегрировать службы для молодежи в сеть комплексных служб планирования семьи, однако при этом, по общему признанию, следует рассматривать отдельно действующие службы в качестве важного дополнительного компонента общей сети.

18. Необходимо обеспечить возможность перестройки деятельности служб в соответствии с изменяющимися потребностями.

19. Деятельность служб для молодежи должна осуществляться с помощью многодисциплинарных бригад.

Персонал служб и его подготовка

20. Персонал, работающий с молодежью в интегрированных службах планирования семьи или в отдельно действующих службах для молодежи, должен пройти определенный курс специальной подготовки, что позволит работникам получить лучшее представление о поведении и сексуальности молодежи.

21. В ходе такого рода подготовки персоналу служб должно быть оказано содействие в осознании своих собственных проблем, связанных с культурными ценностями и сексуальностью, что позволит им с большей ответственностью подходить к проблемам других людей.

22. Все категории персонала должны быть охвачены подготовкой без отрыва от производства, включая учебу на курсах усовершенствования и на постоянных курсах повышения квалификации.

23. Подготовка персонала по вопросам организации служб планирования семьи для молодежи должна включать не только медицинские, но также психологические, социальные и эмоциональные аспекты.

24. Акушерский и соответствующий сестринский персонал должен пройти обучение всем методам предупреждения беременности. В тех случаях, когда существуют законодательные препятствия для такого рода деятельности, эти препятствия должны быть устранены.

Общие положения

Многие аспекты полового воспитания и деятельности соответствующих служб совпадают и взаимно дополняют друг друга. В связи с этим:

25. необходимо координировать на национальном и местном уровнях деятельность учреждений здравоохранения и образования, а также других заинтересованных органов в области полового воспитания и организации деятельности служб планирования семьи; и

26. необходимо развивать сотрудничество на международном уровне между соответствующими межправительственными и неправительственными организациями, проводящими аналогичную деятельность и исследования по вопросам полового воспитания и проблемам, связанным с деятельностью служб для молодежи.

Участники совещания пришли к выводу о том, что было бы целесообразно после подготовки отчета о работе данной группы провести ряд исследований в этой области в различных странах, а через три-четыре года организовать совещание для рассмотрения положения дел.

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